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Issue Date: 25 January 2005

OALJ NO.: 1996-BLA-01383

BRB NO.: 03-0141 BLA

In the Matter of

HAROLD R. TERRY (Deceased)[1]
Claimant

v.

HOBET MINING, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

Mary Z. Natkin, with Student Caseworkers David F. Edelstein and April A. Ballou, (Washington & Lee University School of Law), Lexington, Virginia, for the Claimant

Dorothea J. Clark (Jackson & Kelly PLLC), Morgantown, West Virginia, for the Employer.

THIRD DECISION AND ORDER ON REMAND AWARDING BENEFITS

I. Statement of the Case

This matter, which arises from a second or "duplicate" claim for benefits filed on October 18, 1993 by Harold L. Terry (the Claimant) against Hobet Mining, Incorporated ("Hobet") under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended (the Act), 30 U.S.C. § 901 *et seq*. ("The Act"), is before me a fourth time pursuant to a third remand from the Benefits Review Board (the Board). *See Terry v. Hobet Mining, Inc*., BRB No. 03-0141 BLA (Oct. 31, 2003) (unpublished) (*Terry IV*). The purpose of the Act is "to provide benefits . . . to

[1] The Claimant passed away on July 2, 2003.

coal miners who are totally disabled due to pneumoconiosis and to the surviving dependents of miners whose death was due to such disease; and to ensure that in the future adequate benefits are provided to coal miners and their dependents in the event of their death or total disability due to pneumoconiosis." 30 U.S.C § 901(a).

The Claimant originally filed a claim on July 1, 1980. This claim was heard by Administrative Law Judge Richard E. Huddleston who issued a decision and order denying benefits on April 18, 1989. Judge Huddleston credited the Claimant with twenty-six years of coal mine employment and found that the Claimant had established the existence of pneumoconiosis arising out of coal mine employment, but he concluded that the evidence did not establish that the Claimant was totally disabled by a respiratory or pulmonary impairment. Director's Exhibit 35. The Board affirmed Judge Huddleston's denial of benefits. *Terry v. Hobet Mining & Constr. Co*., BRB Nos. 89-1650 BLA, 89-1650 BLA-A (Dec. 19, 1990) (unpublished) (*Terry I*).

The current proceeding began on October 18, 1993 when the Claimant filed his second claim for benefits under the Act. Director's Exhibit 1. That claim was assigned to Administrative Law Judge Edward Terhune Miller who issued a decision and order denying benefits on October 4, 1995. Judge Miller applied the "duplicate claim" provisions at 20 C.F.R. § 725.309[2] and concluded that denial was warranted because the evidence developed since the previous decision did not establish that the Claimant was totally disabled and, therefore, did not establish a material change in conditions as required by 20 C.F.R. § 725.309(d). Director's Exhibit 58.

Within a year of Judge Miller's denial, the Claimant filed a timely request for modification pursuant to the provisions of 20 C.F.R. § 725.310. The case was assigned to me after the District Director, Office of Workers' Compensation Programs (OWCP) denied the modification request, and the Claimant requested a formal hearing. In a pre-hearing order, I granted the Claimant's motion for partial summary judgment on the issue whether he had pneumoconiosis arising out of coal mine employment based on my finding that this issue had been finally litigated and decided in the Claimant's favor by Judge Huddleston in the first claim. Administrative Law Judge Exhibit 29. After a hearing, I issued a decision and order awarding benefits on November 17, 1998. I found that newly submitted medical opinion evidence established the existence of a totally disabling respiratory impairment as well as a change in conditions supporting modification. In addition, I found that the evidence established that the Claimant's disabling respiratory impairment was due to his pneumoconiosis.

Hobet appealed to the Board which vacated my finding of a change in conditions, holding that I had applied an incorrect legal standard in determining whether modification was appropriate, and it remanded the case to me to determine whether the evidence in the duplicate claim plus the new evidence submitted on modification established the requisite material change

[2] The regulations implementing the Act were amended effective January 19, 2001, and are found at 20 C.F.R. Parts 718, 722, 725 and 726 (2004). All citations to the regulations, unless otherwise noted, refer to the amended regulations. In its most recent decision, the Board rejected Hobet's argument that the amended regulations should not have been applied retroactively in this case because the claim was filed prior to the January 19, 2001 effective date. *Terry IV* at 14.

in conditions pursuant to 20 C.F.R. § 725.309(d). *Terry v. Hobet Mining, Inc.*, BRB Nos. 99-0314 BLA, 99-0314 BLA-A (March 7, 2000) (*Terry II*) . The Board further held that I had erred in finding that collateral estoppel precluded relitigation of the presence of pneumoconiosis issue, and it instructed me to adjudicate this issue on remand in the event I found that the Claimant had established a material change in conditions. *Terry II* at 4-5. The Board also vacated my finding that the medical opinion evidence established total disability, and it instructed me to reweigh the medical opinions with attention to their underlying documentation and reasoning. The Board further instructed me to resolve a conflict in the medical opinions regarding the reliability of the Claimant's diffusing capacity tests for determining the presence of total disability, and it instructed me to weigh together all contrary probative evidence to determine whether the Claimant was totally disabled. Finally, the Board ordered that in the event that I were to find on remand that the Claimant is totally disabled, I must then reweigh the medical opinion evidence to determine whether his total disability was due to pneumoconiosis. *Terry II* at 6-7.

On September 29, 2000, I issued a decision and order on remand awarding benefits. I first found the medical evidence developed subsequent to the denial of his first claim established the presence of a totally disabling respiratory or pulmonary impairment. In this regard, I found that valid and reliable objective tests, including a diffusing capacity test, supported the opinions of physicians who understood that the Claimant's usual coal mine employment job as a front-end loader operator required heavy manual labor and who concluded that a moderate pulmonary impairment prevented him from performing that job. I further found after weighing together all of the contrary probative evidence in accordance with the Board's instructions that the Claimant had established that he was totally disabled by a respiratory or pulmonary impairment. Consequently, I determined that the Claimant had demonstrated a material change in conditions. I next found that the existence of pneumoconiosis arising out of coal mine employment was established based upon the medical opinions of the Claimant's treating physicians. Finally, I found that the weight of credible medical opinion evidence established that the Claimant's total disability is due to pneumoconiosis. Accordingly, I again awarded the Claimant benefits.

Hobet appealed to the Board for a second time, contending that my total disability and material change findings were not supported by substantial evidence and asserting that I made several errors in analyzing and weighing the medical evidence. The Board found that I had properly considered whether the evidence developed since the denial of the first claim for benefits established total disability, and it found no merit in Hobet's contention that I erred in finding a November 1993 diffusing capacity test to be reliable evidence of a totally disabling respiratory impairment. *Terry v. Hobet Mining, Inc*., BRB No. 01-0212 BLA (November 15, 2001) (unpublished) (*Terry III*), slip opinion at 5-6. The Board also rejected Hobet's arguments that I had improperly weighed the medical opinion evidence, and it affirmed my finding that the new medical opinion evidence was sufficient to establish the presence of a totally disabling respiratory or pulmonary impairment. *Terry III* at 6-7. The Board next held that I had adequately weighed the contrary probative evidence in determining whether the Claimant had established total disability, and it affirmed my finding that total disability and, hence, a material change in conditions had been established. *Terry III* at 7-8. However, the Board found merit to Hobet's argument that I had not properly analyzed the x-ray evidence of record in determining whether the existence of pneumoconiosis had been established, commenting that I provided no rationale for my conclusion that the x-ray interpretations are inconclusive, aside from stating that

the evidence was conflicting. Consequently, the Board vacated my finding that pneumoconiosis was established pursuant to 20 C.F.R. § 718.202(a)(1), and it remanded the case with instructions to perform a "qualitative analysis of the x-ray evidence." *Terry III* at 8. Further, the Board agreed with Hobet that in finding that the medical opinion evidence of record established pneumoconiosis, I had not weighed together all categories of relevant evidence bearing on the existence of pneumoconiosis as required by *Island Creek Coal Company v. Compton*, 211 F.3d 203, 210 (4th Cir. 2000) (*Compton*), and it directed me to do so on remand. *Terry III* at 8-9. The Board also suggested that since the case was being remanded, I should reevaluate the medical opinions and fully explain my analysis in light of all the relevant evidence. *Terry III* at 9-10. Finally, the Board vacated my disability causation finding and remanded the case to determine whether pneumoconiosis, if found established, is a substantially contributing cause of the Claimant's total disability as defined in the regulations. *Terry III* at 11.

In my second decision on remand, I found that while a preponderance of the x-ray evidence failed to establish the existence of coal workers' or "clinical" pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1) (2002), the medical opinion was sufficient to establish the existence of "legal" pneumoconiosis pursuant to 20 C.F.R. §718.202(a)(4).[3] In determining that the Claimant had proved the existence of "legal" pneumoconiosis, I credited the medical opinions of his physicians over contrary expert medical opinions introduced by Hobet. I then proceeded to weigh the relevant evidence bearing on the existence of pneumoconiosis together in accordance with the Board's instructions and *Compton*, and after noting *Compton's* holding that evidence negative for the existence of clinical pneumoconiosis should not necessarily be treated as evidence weighing against a finding of legal pneumoconiosis, I concluded that a preponderance of the medical evidence established the existence of pneumoconiosis. Since I further found that the evidence was sufficient to establish that the Claimant was totally disabled due to pneumoconiosis, I again awarded him benefits.

Hobet again appealed to the Board which found several errors in my weighing of the conflicting medical opinions. In light of these errors, the Board vacated my findings that the Claimant had established that he suffered from pneumoconiosis and that his total disability was due to pneumoconiosis, and it remanded the case for further consideration. Pursuant to Hobet's unopposed request, all interested parties were allowed leave to submit written argument limited to the specific issues on which the case was remanded for further consideration. Helpful briefs were received from both Hobet and the Claimant. The Director has not participated in the case on remand.

Upon reconsideration of the evidence in accordance with the Board's instructions, I again find that a preponderance of the evidence establishes that the Claimant suffered from legal pneumoconiosis and that his totally disabling respiratory impairment was due to his pneumoconiosis. Based on these findings, I will award the Claimant's estate the benefits to which he was entitled under the Act.

[3] The finding that the evidence is insufficient to establish the existence of "clinical" pneumoconiosis was not challenged on appeal.

II. Findings of Fact and Conclusions of Law on Remand

In finding that the Claimant had established the existence of legal pneumoconiosis, I credited medical opinions from Drs. Rasmussen, Doyle, Cohen, Koenig and Figueroa over contrary opinions of Drs. Zaldivar, Fino and Hippensteel. I also found that the opinions of Drs. Daniel, Kress and Morgan were not probative as to the existence of legal pneumoconiosis because they only discussed whether there is sufficient evidence to support a diagnosis of clinical pneumoconiosis. The Board held that my analysis and reasons for crediting or not crediting all of these medical opinions was flawed, and it instructed me to reconsider the opinions of Drs. Rasmussen, Doyle, Cohen, Koenig and Figueroa to determine whether they qualify under 20 C.F.R. § 718.202(a)(4) as findings based on the exercise of sound medical judgment that the Claimant suffered from legal pneumoconiosis as defined in the Act and regulations. If, after addressing all of the deficiencies identified by the Board, I find that there is credible medical evidence that the Claimant had legal pneumoconiosis, I must then reassess the opinions from Drs. Zaldivar, Fino, Hippensteel, Daniel, Kress and Morgan, all of which the Board found to be relevant to the existence of legal pneumoconiosis, to determine whether they outweigh any medical findings that the Claimant did have legal pneumoconiosis. Finally, if I again find that the Claimant had legal pneumoconiosis, I must determine whether his total disability was due to his pneumoconiosis.

A. What is "legal" pneumoconiosis?

Considering that this case on remand turns on the question of whether the Claimant suffered from legal pneumoconiosis, it is appropriate to begin with an examination of the concept. The Act itself defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). The regulations recognize that the Act's definition "includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis." 20 C.F.R. § 718.201(a) (internal quotation marks in original). Further, the regulations provide the following comprehensive definition of "clinical" and "legal" pneumoconiosis:

> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This

definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201. Physicians do not always make a clear distinction in their reports and testimony between "clinical" and "legal" pneumoconiosis, and the Court of Appeals for the Fourth Circuit had repeatedly admonished ALJs and the Board to "bear in mind when considering medical evidence that physicians generally use 'pneumoconiosis' as a *medical* term that comprises merely a small subset of the afflictions compensable under the Act." *Barber v. Director, OWCP*, 43 F.3d 899, 901 (1995) (quotation marks and italics in original).

B. Is there credible medical evidence that the Claimant had legal pneumoconiosis?

The first question to be addressed on remand is whether any of the opinions from Drs. Rasmussen, Doyle, Cohen, Koenig and Figueroa qualify as a finding of legal pneumoconiosis that is based on sound medical judgment and objective medical evidence and supported a reasoned medical opinion as required by section 718.202(a)(4) of the regulations.[4]

Dr. Rasmussen

With regard to Dr. Rasmussen, the Board agreed with Hobet's argument that I "failed to address the equivocal nature of Dr. Rasmussen's opinion." *Terry IV* at 11. In this regard, the Board stated,

> In his June 15, 1994 report, Dr. Rasmussen diagnosed "questionable occupational pneumoconiosis" and "COPD with emphysema." Director's Exhibit 30. Dr. Rasmussen attributed claimant's COPD with emphysema to "[p]ossible coal dust exposure." *Id.* Dr. Rasmussen also opined that it was "possible" that claimant's coal mine dust exposure was a significant contributing factor to his totally

[4] Section 718.202(a)(4) states,

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in Sec. 718.201. Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

20 C.F.R. 718.202(a)(4).

> disabling respiratory insufficiency. *Id.* The administrative law judge erred in crediting Dr. Rasmussen's opinion without addressing its speculative nature.

Id. (citations and footnotes omitted) The Board also held that Dr. Rasmussen's opinion in a supplemental report July 21, 1997 (Claimant's Exhibit 16) that the Claimant suffered from coal workers' pneumoconiosis arising out of his coal mine employment constitutes "a finding of clinical pneumoconiosis" and that I "failed to explain how this diagnosis supported a finding of 'legal' pneumoconiosis." *Id.* at n.12 (internal quotation marks in original).

Taking up the Board's second criticism first, Dr. Rasmussen made two distinct cardiopulmonary diagnoses when he examined the Claimant in 1994: "1. Questionable occupational pneumoconiosis – 26+ years history of coal mine employment, and controversial x-ray changes, not typical of CWP or silicosis" caused by coal mine dust exposure" and "2. COPD with emphysema – severe airway obstruction and decreased SBDLCO" caused by "possible coal mine dust exposure." Claimant's Exhibit 30 at 4. Dr. Rasmussen explained that in view of the negative x-ray interpretations, "[a] diagnosis of occupational pneumoconiosis could not be made." *Id.* at 7. He then addressed the cause of the Claimant's respiratory impairment as follows:

> The only known risk factors for this patient's disabling respiratory insufficiency are his occupational dust exposure and his cigarette smoking. By history the latter is quire minimal. It is possible that the patient's coal mine dust exposure has been a significant contributing factor to his totally disabling respiratory insufficiency.

Id. In 1997, Dr. Rasmussen revisited his 1994 diagnoses in light of a substantial body of additional medical evidence that had been developed. Regarding his prior determination that a diagnosis of "occupational pneumoconiosis" could not be made, he explained that based on the negative x-ray interpretations, "a clinical diagnosis of coalworkers' pneumoconiosis was not possible." Claimant's Exhibit 16 at 2. After noting that the medical record now contained several positive x-ray interpretations, Dr. Rasmussen further stated that "[b]ased on the multiple positive readings of x-rays and the patient's long history of occupational dust exposure, it is medically reasonable to conclude that he has coalworkers' pneumoconiosis which arose from his coal mine employment." *Id.* at 3. He then went on to discuss the Claimant's pulmonary function and arterial blood gas studies, noting that they showed abnormalities but not a disabling impairment, and the results of a 1993 single breath carbon monoxide diffusing capacity study which showed a moderate to marked pulmonary impairment that was sufficient to render the Claimant totally disabled from his last regular coal mine job. *Id* Dr. Rasmussen explained that a single breath diffusing capacity test can show a gas exchange impairment even when ventilatory studies are normal, and he concluded,

> Based on all of the above, it is my opinion that Mr. Terry suffers from coal workers' pneumoconiosis which arose from his coal mine employment and that his coal mine dust exposure is a significant contributing factor in his disabling respiratory insufficiency.

Id. at 4. I agree that the first part of this opinion (*i.e.*, that the Claimant suffers from "coalworkers' pneumoconiosis arising out of his coal mine employment") constitutes, as the Board held, a finding of clinical pneumoconiosis. However, I find that the second part of the doctor's opinion (*i.e.*, "that his coal mine dust exposure is a significant contributing factor to his disabling respiratory insufficiency") clearly qualifies as a diagnosis of legal pneumoconiosis within the meaning of the regulations. *See* 20 C.F.R. § 718.201(b) (disease arising out of coal mine employment includes any pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment). Indeed, given Dr. Rasmussen's substantial experience in conducting examinations under the Act,[5] and reading both of his reports in their entirety, it is only reasonable to find, as I do, that he made precisely the distinction between clinical and legal pneumoconiosis that the Act, regulations and *Barber* require. I also find that Dr. Rasmussen's finding of legal pneumoconiosis is based upon objective medical evidence and supported by a reasoned medical opinion because he grounded his finding on the results of the ventilatory, arterial blood gas and diffusing capacity studies in addition to the Claimant's histories of coal mine dust exposure and cigarette smoking, and because he explained why he attributed the Claimant's disabling respiratory impairment to coal mine dust exposure rather than his "quite minimal" cigarette smoking. *See Cornett v. Benham Coal, Inc.*, 27 F.3d 569, 576 (6th Cir. 2000) (medical opinions sufficiently reasoned where based on physical examinations, smoking and mining histories and pulmonary function studies).

Regarding the Board's criticism that I failed to address the "equivocal" or "speculative" nature of Dr. Rasmussen's medical opinion, it is true that Dr. Rasmussen used the term "possible" when discussing the causes of the Claimant's disabling respiratory impairment in his 1994 report. However, the Claimant's attorneys point out in their brief on remand that the Fourth Circuit has held that a physician's use of conditional language does not, perforce, make the physician's opinion equivocal. Claimant's Brief on Remand at 13-14, citing *Piney Mountain Coal Co. v. Mays*, 176 F.3d 753 (4th Cir. 1999). In *Mays*, the Court stated that it was reasonable to interpret a physician's statement that pneumoconiosis "could" have been a complicating factor in a miner's death "as simply acknowledging the uncertainty inherent in medical opinions while nonetheless offering a positive opinion about Mays's cause of death." *Id.* at 763. The Court explained that,

> [A]reasoned medical opinion is not rendered a nullity because it acknowledges the limits of reasoned medical opinions. Many wise speakers choose their words carefully and conservatively, never overstating as certain an opinion that admits of any doubt, and some timid ones unnecessarily couch a sound message in noncommittal language. Still others "believe passionately in the palpably not true," and forgo no opportunity to share these beliefs. In sum, the reliability of a given opinion is not necessarily revealed by the forcefulness of the speaker's language.

Id. (footnote omitted). The Court also cautioned that a trier of fact should not focus on "single

[5] *See* Senate Report No. 92-743, 92d Cong., 1st Sess., 1972 US Code, Cong. and Adm. News 2305, 3218-19, observing that Dr. Rasmussen "has probably made more intensive examinations of miners than any other physician."

words" but instead on the "full context" of a physician's opinion. *Id.* With this guidance in mind, I find, after considering the full context of Dr. Rasmussen's reports, that his opinion is not fatally equivocal or speculative. As set out above, Dr. Rasmussen stated in his 1994 report that "the only known risk factors for the Claimant's disabling respiratory insufficiency are his occupational dust exposure and his cigarette smoking." Director's Exhibit 30 at 7. In the next sentence, he further stated, "By history the latter [cigarette smoking] is quite minimal." *Id.* This statement necessarily implicates coal mine dust exposure as a contributing cause. Moreover, any equivocation was removed three years later when Dr. Rasmussen wrote without reservation or qualification in his 1997 report that the Claimant's coal mine dust exposure was a significant contributing factor to his disabling respiratory impairment. Claimant's Exhibit 16 at 4. Thus, it is clear that Dr. Rasmussen, by describing the Claimant's cigarette smoking history as quite minimal, formed the positive and reasoned opinion that exposure to coal mine dust significantly contributed to the Claimant's respiratory impairment and that his use the conditional word "possible" in 1994 was nothing more than a product of his caution in expressing a medical opinion on a question that was not free of all doubt. In my view, it would be grossly unreasonable on this record to reject Dr. Rasmussen's opinion as equivocal. To do so would serve to penalize the cautious expert while rewarding those who express their opinions passionately, loudly and in absolute terms, thereby reducing adjudication of claims under the Act to a contest of counting decibel levels over substance.

In determining that Dr. Rasmussen's reasoned diagnosis of legal pneumoconiosis is not equivocal or speculative, I have considered *U.S. Steel Mining Co. v. Director, OWCP*, 187 F.3d 384, 389 (4th Cir. 1999) which Hobet cites for the proposition that use of words such as "could" and "possible" strip an expert's opinion of probative value. Hobet Brief on Remand at 22-23, addressing Dr. Koenig's report. While the cited case does bear some superficial similarity to the instant case, especially since the expert opinion in question was authored by Dr. Rasmussen, I find that case is distinguishable. In *U.S. Steel*, the ALJ relied solely on the following opinion from Dr. Rasmussen in concluding that pneumoconiosis was a substantially contributing cause or factor leading to a miner's death:

> The patient developed carcinoma of the lung in 1992 and underwent a pneumonectomy on the right. There is no evidence of link his coal mine dust exposure with his carcinoma of [sic] the lung. He certainly had an adequate smoking history to be considered a causative factor.
>
> During the patient's final hospitalization at Raleigh General Hospital he did develop a left lower lobe pneumonia which failed to respond to antibiotics. He was discharged to Hospice care. There is no information concerning his final events or the exact circumstances of his death. It is possible that death could have occurred as a consequence of his pneumonia superimposed upon his chronic lung disease, including his occupational pneumoconiosis and occupationally related emphysema. It can be stated that the patient's occupational pneumoconiosis was a contributing factor to his death.

187 F.3d at 387. Noting that Dr. Rasmussen had properly acknowledged that there was no evidence in the record that could link the miner's coal mine dust exposure to his carcinoma, the

Court held that Dr. Rasmussen's statements amounted to pure speculation which did not constitute a reasoned opinion that pneumoconiosis contributed to the patient's death and, therefore, did not qualify as "reliable, probative, and substantial" evidence necessary to sustain the claimant's burden of proof. *Id.* at 389-390. In contrast to *U.S. Steel*, Dr. Rasmussen explained in this case that there is evidence in this record, specifically the Claimant's history of coal mine dust exposure and test results showing that he had the type of respiratory impairment that is known to be caused by exposure to coal mine dust and cigarette smoke, to establish the causal link between his respiratory impairment and coal mine employment that is necessary to support a diagnosis of legal pneumoconiosis. Thus, *U.S. Steel* is readily distinguishable, and I conclude that Dr. Rasmussen's reports contain a reasoned finding under section 718.202(a)(4) that the Claimant suffered from legal pneumoconiosis.

Dr. Doyle

The Board rejected my finding that Dr. Doyle's reports qualified as a diagnosis of legal pneumoconiosis, stating,

> The administrative law judge also failed to explain how Dr. Doyle's reference to COPD in his office notes supported a finding of "legal" pneumoconiosis. Decision and Order on Remand at 24; Director's Exhibit 42. Dr. Doyle also prepared a report dated March 9, 1998, wherein he diagnosed pneumoconiosis "[b]ased upon radiographic findings, evidence of impairment, and clinical history." Claimant's Exhibit 26. Although the administrative law judge noted that Dr. Doyle opined that both cigarette smoke and coal dust contributed to claimant's respiratory impairment, the administrative law judge failed to address whether Dr. Doyle's diagnosis of pneumoconiosis constituted a finding of "clinical" pneumoconiosis or "legal" pneumoconiosis. Decision and Order on Remand at 24.

BRB slip op. at 12. I find that the diagnosis of pneumoconiosis quoted above by the Board constitutes a finding of clinical rather legal pneumoconiosis as it was made in the context of Dr. Doyle's discussion of surgical reports and histologic findings of fibrosis and fibrotic adhesions. Claimant's Exhibit 26 at 2. But Dr. Doyle did not stop there. He also stated in his March 9, 1998 report,

> Mr. Terry gives a history of being a light smoker for many years and being exposed to coal dust for a period of about 26 years. The National Institute of Occupational Safety & Health published a criteria document that provides an extensive review of epidemiological research pertaining to the health risks associated with exposure to coal mine dust over a working lifetime. This research clearly demonstrates that coal miners have an elevated risk of developing pneumoconiosis and the kind of pulmonary impairment that is affecting Mr. Terry. Therefore, it is my opinion that his exposures to cigarette smoke and coal dust have both contributed to his disability.

Id. (footnote omitted).[6] In my view, Dr. Doyle, like Dr. Rasmussen, clearly recognized the appropriate distinction between clinical and legal pneumoconiosis, and he made an additional diagnosis of legal pneumoconiosis in the above-quoted paragraph by attributing the Claimant's disabling pulmonary impairment to his exposure to coal dust as well as cigarette smoke. I also find that his opinion is sufficiently reasoned in that he discussed the Claimant's medical, mining and cigarette smoking histories, and the results of the pulmonary function, arterial blood gas and diffusing capacity studies, and he explained, by reference to the NIOSH compilation of epidemiological studies, how exposure to coal mine dust elevates a miner's risk of developing the type of pulmonary impairment that affected the Claimant. Accordingly, I will treat Dr. Doyle's opinion as a reasoned finding under section 718.202(a)(4) that the Claimant suffered from legal pneumoconiosis.

Dr. Cohen

The Board held that I erred in crediting Dr. Cohen's opinion without addressing whether it is sufficiently reasoned. In a letter to the Claimant's attorneys dated March 22, 1998, Dr. Cohen stated that he had reviewed the results of several pulmonary function, arterial blood gas and diffusing capacity studies as well as Dr. Doyle's report of March 9, 1998. Claimant's Exhibit 32. In addition to agreeing with Dr. Doyle's assessment that the Claimant's degree of pulmonary impairment would have prevented him from returning to his last coal mine job, Dr. Cohen stated,

> And, it is medically reasonable to conclude that his exposure to cigarette smoke and coal worker's pneumoconiosis have both contributed to his pulmonary insufficiency, especially since the impairment in diffusing capacity is significantly greater than the impairment in ventilatory function. If the etiology was only cigarette smoke, I would expect to see more obstructive impairment.

Id. at 2. While Dr. Cohen's opinion is generally supportive of Dr. Doyle who, as I have determined, made a reasoned finding that the Claimant suffered from legal pneumoconiosis, I find that his report, standing alone, does not constitute a reasoned diagnosis of legal pneumoconiosis pursuant to section 718.202(a)(4). That is, I find that his reference to "coal worker's pneumoconiosis" amounts to a diagnosis of clinical rather than legal pneumoconiosis. *See Terry IV* at 13 (holding that "Although Dr. Figueroa referenced the "legal" definition of pneumoconiosis, his finding of "coal miners pneumoconiosis" constitutes a diagnosis of "clinical" pneumoconiosis, not "legal" pneumoconiosis."). Accordingly, I will not give his opinion any weight in the process of determining whether there is sufficient evidence in the record to establish that the Claimant suffered from legal pneumoconiosis.[7]

[6] The NIOSH publication cited by Dr. Doyle is Criteria for a Recommended Standard I Occupational Exposure to Respirable Coal Mine Dust, U.S. Department of Health and Human Services (Sept. 1995).

[7] Although the Board did not specifically instruct me to reconsider whether Dr. Cohen's opinion constitutes a finding of legal pneumoconiosis, its instruction that I address whether his opinion is adequately reasoned for section 718.202(a)(4) purposes is sufficiently broad to encompass the legal pneumoconiosis versus clinical pneumoconiosis issue. Moreover, failure to consider this question assuredly would result in another remand, as the record of this case demonstrates, in the event that benefits are again awarded to the Claimant.

Dr. Koenig

The Board agreed with Hobet that I failed to address the "speculative nature" of Dr. Koenig's opinion. *Terry IV* at 12. The Board also quoted the following excerpt from Dr. Koenig's report to point out his use of "speculative" language:

> [T]here is no question that cigarette smoking and asthma can, in and of themselves, explain [claimant's] pulmonary function test abnormalities, bullous emphysema, and recurrent pneumothoraces. In fact, you don't even need to invoke asthma. COPD alone could explain all the findings. However, based on the medical literature, **coal dust exposure alone, independent of smoking, and without the presence of simple coal workers' pneumoconiosis, could also account for his respiratory findings and impairment.** To claim that [claimant's] respiratory disability has nothing to do with coal mine dust exposure and could only be due to smoking and asthma would be disregarding numerous methodologically valid studies in the medical literature. Moreover in his statement, Dr. Zaldivar gave no evidence of logical reasoning to support his claims that [claimant's] smoking and asthma, and not his coal mining work, caused his respiratory impairment. He simply said it was so.

*Id.*at n.13, quoting from Claimant's Exhibit 4 at 4 (emphasis in original). I have carefully reread Dr. Koenig's report in its entirety and find that it is not at all speculative. The excerpt quoted by the Board appears in the concluding paragraph of Dr. Koenig's three-page report. As I discussed in some detail in the last decision on remand, the focus of Dr. Koenig's report is a point-by-point rebuttal of Dr. Zaldivar's opinions. When properly considered in context, it is clear that Dr. Koenig's use of terms such as "could explain" and "could also account" are simply a rhetorical technique that he employed to counter Dr. Zaldivar's reasoning, which is often accompanied by hyperbolic language, that it makes no medical sense to consider whether coal mine dust exposure could have contributed to the Claimant's pulmonary impairment because the impairment is readily explained by the diagnoses of non-occupational asthma and emphysema.[8] At very worst, I find that Dr. Koenig's use of conditional terms in expressing his medical opinion is, as the Court recognized in *Mays* and as I have determined in regard to Dr. Rasmussen's use of similar language, attributable to normal scientific caution which does not provide a basis for rejecting his opinion as speculative or equivocal.[9] Therefore, I find it most reasonable to construe Dr.

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[8] As recounted in my second decision on remand, Dr. Zaldivar testified that it is "unthinkable to blame" the Claimant's occupation for his pneumothoraces; Hearing Transcript ("TR") at 67; that "there is absolutely no relationship" between the Claimant's pneumothoracies and his employment; TR 103-05; and that that he was "absolutely sure" and "100 percent certain" of the correctness of his opinions. TR 119, 127-128.

[9] For the reasons discussed above in connection with Dr. Rasmussen's opinions, I reject Hobet's argument that *U.S. Steel* requires me to discount Dr. Koenig's opinion as speculative because he used conditional language. I have also considered the cases cited by the Board as guidance in addressing whether Dr. Koenig's opinion is speculative. *See Terry IV* at 12, citing *Justice v. Island Cteek Coal Company*, 11 BLR 1-91, 1-94 (1988) and *Campbell v. Director, OWCP*, 11 BLR 1-16, 1-19 (1988). In both cases, the Board held that it was within the ALJ's discretion to reject a medical opinion as equivocal or doubtful. Neither decision describes the discredited opinions, thus precluding any meaningful comparison with Dr. Koenig's report, and I have exercised my discretion as the trier of fact in this case to find that Dr. Koenig's opinion is not so speculative as to deprive it of any probative value.

Koenig's report as setting forth a positive finding that exposure to coal dust, even absent evidence of clinical pneumoconiosis, significantly contributed to the Claimant's respiratory condition and impairment. This qualifies as a diagnosis of legal pneumoconiosis. Further, I find that Dr. Koenig's opinion is sufficiently reasoned since he considered the Claimant's mining and smoking histories and test results, and he provided a well-documented explanation of why his conclusion that coal dust exposure contributed to the Claimant's lung abnormalities and impairment is better supported by the medical literature than Dr. Zaldivar's opinion to the contrary.[10]

Dr. Figueroa

The Board effectively reversed my finding that Dr. Firueroa's opinion contained a diagnosis of legal pneumoconiosis when it stated that "[a]lthough Dr. Figueroa referenced the "legal" definition of pneumoconiosis, his finding of "coal miners pneumoconiosis" constitutes a diagnosis of "clinical" pneumoconiosis, not "legal" pneumoconiosis." *Terry IV* at 13. The Claimant's attorneys argue that in addition to diagnosing "coal workers' pneumoconiosis" in his September 19, 1995 report, Dr. Figueroa stated that the Claimant's apical bulli "in a certain way could be related to an underlying emphysema" and that the Claimant's spontaneous pneumothorax "is probably multifactorial in origin." However, he did not identify what the multiple factors were, nor did he connect the Claimant's bulli, emphysema, pneumothorax or respiratory impairment to the Claimant's coal mine employment. Therefore, in light of the Board's ruling, I conclude that Dr. Figueroa's reports do not provide a reasoned finding pursuant to section 718.202(a)(4) that the Claimant had legal pneumoconiosis.

Other Physicians

The Claimant's attorneys also argue that reports from Drs. Imam and Marciales are supportive of the other physicians' diagnoses of conditions satisfying the legal definition of pneumoconiosis. Claimant's Brief on Remand at 15 n.2, 17-18. Dr. Imam, who is associated with the same practice as Dr. Doyle, stated in a letter dated March 12, 1998 that he had reviewed Dr. Doyle's March 9, 1998 letter and concurred with his assessment. Claimant's Exhibit 25. Dr. Imam further stated that "[b]ased on the medical evidence and history of exposure to coal mine dust, it is medically reasonable to conclude that that this patient has coal workers' pneumoconiosis, that his respiratory impairment would prevent him from performing heavy physical labor, and that his exposure to coal dust and cigarette smoke have both contributed to his disability." *Id.* Consistent with the Board's rulings, I find that Dr. Imam's reference to coal workers' pneumoconiosis constitutes a diagnosis of clinical pneumoconiosis. However, given the fact that Dr. Imam agreed with the assessment of Dr. Doyle, who found that the Claimant suffered from both clinical and legal pneumoconiosis, and since he stated that exposure to coal dust contributed to the Claimant's respiratory disability, I also find that his opinion is supportive of Dr. Doyle's reasoned diagnosis of legal pneumoconiosis.

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[10] Hobet additionally argues that Dr. Koenig's opinion should be given less weight because he only reviewed a report from Dr. Zaldivar, while several of Hobet's experts, including Dr. Zaldivar, reviewed all available medical records. Hobet Brief on Remand at 22-23. This argument will be addressed *infra* in the section of this decision dealing with the weighing of the conflicting medical opinions.

Dr. Marciales, who practices with Dr. Figueroa and treated the Claimant for his episode of partial pneumothorax, wrote to Judge Miller in a letter dated September 14, 1995, stating that the Claimant had "coal workers' pneumoconiosis" evidenced by a moderate restrictive pattern in pulmonary function testing and complicated by bilateral bullae in his lungs. Director's Exhibit 53. Dr. Marciales further stated that the Claimant's pulmonary function tests, though somewhat limited, revealed at least a moderate restrictive pattern and that blood gasses revealed the presence of hypoxemia and mild respiratory alkalosis which is consistent with at least moderate to severe interstitial lung disease. *Id.* Dr. Marciales added that "coal workers' pneumoconiosis produces bulli which produced two episodes of spontaneous pneumothorax." *Id.* In a subsequent letter dated July 1, 1997, Dr. Marciales stated that it was his opinion that the Claimant suffered from "coal worker pneumoconiosis" and that "[b]ased on the clinical history and due to the fact that the patient has had two lung collapses (pneumothorax) and in consideration that his CT scan shows the presence of nodular fibrosis and bullae, I think that the pneumothorax was related to his pneumoconiosis." *Id.* Unlike Drs. Rasmussen, Doyle and Koenig, Dr. Marciales only diagnosed coal workers' or clinical pneumoconiosis, and he did not otherwise attribute any of the Claimant's lung abnormalities to his coal mine employment. Consequently, I find that his reports do not contain a reasoned finding of legal pneumoconiosis.

In sum, after reconsidering the medical opinions of Drs. Rasmussen, Doyle, Cohen, Koenig and Figueroa in accordance with the Board's instructions, I find that Drs. Rasmussen, Doyle and Koenig provided reasoned diagnoses of legal pneumoconiosis pursuant to section 718.202(a)(4), that Dr. Doyle's finding of legal pneumoconiosis is corroborated by the opinion of Dr. Imam, and that the opinions from Drs. Cohen, Figueroa and Marciales cannot be considered as reasoned findings of legal pneumoconiosis.

C. Is medical opinion evidence sufficient to establish legal pneumoconiosis?

Having determined that the opinions of Drs. Rasmussen, Doyle and Koenig qualify as reasoned findings of legal pneumoconiosis pursuant to section 718.202(a)(4), I must now reconsider the opinions of Drs. Zaldivar, Fino, Hippensteel, Daniel, Kress and Morgan to determine whether they outweigh the medical findings of legal pneumoconiosis. In conducting this analysis, the Board instructed that I "should address the comparative credentials of the respective physicians, the explanations of their conclusions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses." *Terry IV* at 13.

Dr. Zaldivar

In my earlier decision, I gave little weight to Dr. Zaldivar's opinion that the Claimant did not suffer from legal pneumoconiosis. In this regard, I found, after careful examination of his testimony at the hearing, that he had not provided "credible reasons" in support of his opinion, noting that while he had testified that the Claimant's breathing problems were the result of emphysema and asthma and that emphysema and asthma are not caused by coal dust, he was unwilling to answer the critical question of whether exposure to coal dust can contribute to or aggravate emphysema. Second D&O on Remand at 27-27. I also concluded that Dr. Zaldivar's opinions were at odds with the broad definition of legal pneumoconiosis contained in the Act and

regulations. *Id.* at 27. The Board held that these "bases for discrediting Dr. Zaldivar's opinion that claimant does not suffer from 'legal' pneumoconiosis cannot stand." *Terry IV* at 7 (quotation marks in original). With regard to whether Dr. Zaldivar's opinions are hostile to the Act, the Board's findings are clear, and I am precluded from rejecting his opinions on this basis. However, I am concerned that the Board did not fully appreciate the other reason I relied upon in discrediting Dr. Zaldivar's opinion that the Claimant did not have legal pneumoconiosis. Therefore, I will attempt to clarify my findings in a manner that is consistent with the Board's instructions.

As to whether Dr. Zaldivar provided reasons to support his opinion that the Claimant did not have legal pneumoconiosis, the Board examined the transcript of his testimony at the hearing and found that he did. Specifically, the Board quoted at length from Dr. Zaldivar's testimony at pages 104-105, 138-139 and 150-151 of the hearing transcript in finding that he explained why the Claimant's coal mine employment did not cause or contribute to his lung abnormalities including his emphysema. *Terry IV* at 4-6. The Board further stated,

> Dr. Zaldivar opined that claimant's coal dust exposure did not contribute to his blebs, bullae, recurring pneumothoracies, emphysema or asthma. Transcript at 117. Dr. Zaldivar also opined that claimant's coal dust exposure did not make him more susceptible to his pulmonary problems. *Id.* at 118. Dr. Zaldivar also specifically opined that claimant did not suffer from "legal" pneumoconiosis. Transcript at 154-155. Thus, contrary to the administrative law judge's characterization, Dr. Zaldivar provided detailed reasons for finding that claimant did not suffer from "legal" pneumoconiosis.

Id. at 6. Unfortunately, this analysis misses the intended point which, in fairness to the Board, probably should have been made more emphatically. I never found that Dr. Zaldivar did not provide any reasons to support his opinion that the Claimant did not suffer from legal pneumoconiosis. Rather, I found that the reasons were not credible based on my assessment of the record and his testimony at the hearing in particular. Dr. Zaldivar did, as the Board found, articulate reasons for his opinions. And, he did respond "no" when he was given the Act's definition of legal pneumoconiosis by Hobet's attorney and asked whether the Claimant had "legal pneumoconiosis." Hearing Transcript at 154-155. However, most of his testimony addressed the underlying causes of the Claimant's lung problems and whether inhalation of coal dust or "coal workers' pneumoconiosis" caused his blebs, pneumothoracies, asthma and emphysema. Hence, the line of questioning quoted in my second decision and order on remand at pages 26-27, which was directed to Dr. Zaldivar on cross-examination and by the Court to elicit an answer as to whether he believed that coal mine dust exposure could have contributed to any of the Claimant's lung problems, was crucial because it explored Dr. Zaldivar's rationale for concluding that the Claimant did not have any lung condition meeting the Act's broad definition of legal pneumoconiosis. Dr. Zaldivar would not answer these questions directly, and I find that his testimony on this critical point was evasive and argumentative. For these reasons, and considering that the record reveals that Dr. Zaldivar is a highly intelligent and precise medical expert with extensive experience in evaluating miners for the presence of lung conditions that are compensable under the Act, it is reasonable to infer, as I do, that his responses were purposefully evasive and lacking complete candor. While the Board has ruled that I may not discredit Dr.

Zaldivar's opinion on the ground that he provided no reasons to support his statement that the Claimant did not have legal pneumoconiosis, it is the ALJ's statutory responsibility to make credibility determinations and draw reasonable inferences from the evidence. *See Newport News Shipbuilding and Dry Dock Co. v. Cherry*, 326 F.3d 449, 452 (4th Cir. 2003); *Bolden v. G.A.T.X. Terminals Corp*., 30 BRBS 71, 73 (1996). Since I do not believe that my assessment of Dr. Zaldivar's credibility as a witness is irrational or unexplained, I find that it is appropriate to take this assessment into consideration, along with Dr. Zaldivar's credentials and the other factors identified by the Board, in comparing the persuasiveness of his opinions to the findings of legal pneumoconiosis made by Drs. Rasmussen, Doyle and Koenig. I will now turn to this comparison.

Dr. Zaldivar's medical reports and testimony have already been discussed in detail in my past decisions and by the Board, so they need not be repeated extensively. On the question of whether the Claimant had legal pneumoconiosis, he testified that the Claimant's coal dust exposure did not contribute to his blebs, bullae, recurring pneumothoracies, emphysema or asthma. Hearing Transcript at 117. He stated that pulmonary function testing confirmed that the Claimant had a reversible airway obstruction, that the medical records showed that the Claimant had been prescribed bronchodilator medications which are used to treat asthma, and that the Claimant had given him a history of cold-induced wheezing and shortness of breath, all of which he characterized as complaints of an individual with asthma "which is a disease of the general population not related to coal mine dust and not coal workers' pneumoconiosis." Employer's Exhibit 1 at 8. Dr. Zaldivar attributed the Claimant's "bullous emphysema" to a combination of congenital abnormalities and cigarette smoking. Employer's Exhibit 1 at 9. He also testified that this is a case where it is possible to separate the effects of cigarette smoking from the effects of coal dust exposure; Hearing Transcript at 168; and he stated that the bullous emphysema which Claimant had is different from "focal emphysema" which is present when one suffers from clinical pneumoconiosis. *Id.* at 138, 156. Because he felt that the Claimant's non-occupational bullous emphysema and asthma adequately explained his respiratory impairment, Dr. Zaldivar stated that it does not make medical sense to consider the Claimant's coal mine dust exposure as an additional cause. *Id.* at 159; Employer's Exhibit 6 at 48.

Dr. Koenig reviewed Dr. Zaldivar's May 14, 1997 report and stated that he agreed with many of Dr. Zaldivar's findings including the following: (1) that the Claimant's pulmonary function testing showed that he had an chronic airway obstruction or obstructive lung disease which had been reversed in one study, suggesting an asthmatic component; (2) that his chest x-rays and CT scans are consistent with recurrent pneumothoraces and bullous emphysema; (3) that bullae, which can enlarge over time, are lung cavities that are congenital as well as a product of emphysema; and (4) the Claimant's pneumothoraces are likely due to the bullae in his lungs. Claimant's Exhibit 4 at 1. At the same time, Dr. Koenig disagreed sharply with Dr. Zaldivar's opinions on the cause(s) of the Claimant's lung condition and respiratory impairment. Specifically, he cited several studies that have shown that coal dust exposure, independent of smoking, causes the same type of emphysema as cigarette smoking, and he added that "since bullae and pneumothoraces are known complications of emphysema due to smoking, there is no reason to think that they could not complicate the emphysema secondary to coal dust as well." *Id*. at 2. He further stated that reversible airflow obstruction and airway hyperactivity, the component of asthma which accounts for irritants such as cold air causing or increasing shortness

of breath, have also been associated with coal mining as well as exposure to other dusts, "[t]hus, the presence of reversible airflow obstruction on pulmonary function tests, symptoms consistent with asthma . . . or treatment with asthma medications . . . cannot be used as evidence that Mr. Terry's obstructive lung disease is secondary to asthma or smoking and not coal dust exposure." *Id.* Finally, he stated that while cigarette smoking and asthma could, as Dr. Zaldivar asserts, explain the Claimant's pulmonary function test abnormalities, bullous emphysema and recurrent pneumothoraces, the medical literature shows that "coal dust exposure alone, independent of smoking and without the presence of simple coal workers' (*i.e.*, clinical) pneumoconiosis, could also account for [the Claimant's] respiratory findings and impairment." *Id.* at 2-3 (underlining in original). Thus, Dr. Koenig stated that "[t]o claim that [the Claimant's] respiratory disability has nothing to do with coal mine dust exposure and could only be due to smoking and asthma would be disregarding numerous methodologically valid studies in the medical literature." *Id.* at 3.

Dr. Zaldivar was provided an opportunity to respond to Dr. Koenig's report during a pre-hearing deposition. He charged that Dr. Koenig did not accurately reflect his opinions, specifically responding, "I never said that coal workers' pneumoconiosis causes a restrictive disease with low lung capacity" and stating, "I certainly resent a little bit being misquoted so badly in his report." Employer's Exhibit 6 at 42-43.[11] However, he did not identify any other allegedly inaccurate characterizations of his opinions by Dr. Koenig. Dr. Zaldivar was also asked to respond to Dr. Koenig's statement that there is no reason to think that bullae and pneumothoraces could not complicate emphysema caused by coal dust because there is no difference between the type of emphysema caused by coal dust and the type caused by smoking and because bullae and pneumothoraces are known complications of emphysema due to smoking, and he testified,

> A. Well I believe that he must be misquoting the literature as badly as he misquoted me. Centrilobular emphysema is not the description given to coal workers' pneumoconiosis that produces emphysema. The so-called emphysema [caused by] coal workers' pneumoconiosis is a focal emphysema. And by emphysema, the pathologist does not necessarily mean lung destruction. The pathology means enlargement of airways beyond what is considered normal, And these occur distal to the macules which are the fibrotic areas present in the respiratory bronchioles which are the response of the lungs to the inhaled dust. These macules are proximal to the focal areas of airway dilatation which is described by the pathologists as emphysema, which is different from centrilobular emphysema which is true destruction of lung tissue. Without the macule, one does not have coal workers' pneumoconiosis. And the presence of the macule establishes that the so-called emphysema distal to them is focal emphysema,

[11] Dr. Koenig wrote in his report that "Dr. Zaldivar states or implies the following:

> (1) To have significant pulmonary of lung impairment from coal dust exposure, you must have evidence of coal workers' pneumoconiosis (CWP) = interstitial lung disease = lung fibrosis on chest X-ray and lung function tests, the latter demonstratine "restrictive" disease = a low total lung capacity.

Claimant's Exhibit 4 at 1.

> separate and distinct from centrilobular emphysema for smokers. So I think that once again he's misquoting the literature.

Id. at 43-44. He further testified that it is not possible to say that the Claimant's pneumothoraces were aggravated by coal dust exposure because the collapse of a lung is due to particular abnormalities -- bullae leading to a rupture of the lung -- that are "never caused by coal workers' pneumoconiosis . . . [s]o inhalation of coal dust did not cause nor contribute to the formation of bullae that resulted in the pneumothoraces." *Id*. at 46. Unlike Dr. Koenig, Dr. Zaldivar did not cite any studies or other medical research to support his opinions, and he did not identify or otherwise explain where Dr. Koenig had misquoted the medical literature.

In terms of weighing the relative persuasiveness of the conflicting opinions on the presence of legal pneumoconiosis, I initially note that Drs. Zaldivar and Koenig possess similar qualifications as medical experts. Both are board-certified in internal medicine and in the specialties of pulmonary disease and sleep medicine. Employer's Exhibit 1 at 16-17; Claimant's Exhibit 4 at 5-15.[12] Dr. Zaldivar is also a certified "B-reader" for chest x-rays, while Dr. Koenig has additional board-certification in critical care medicine, and he is a board-certified medical examiner. *Id.* Both have teaching appointments at medical schools, and both have published research articles, although Dr. Koenig's list of publications is significantly more impressive. In short, Drs. Zaldivar and Koenig are well-qualified experts, but I do not find their qualifications to be indistinguishable. The advantage, I find, in this rather close contest of comparative credentials goes to Dr. Koenig in view of his additional qualification as a board-certified medical examiner and his greater level of accomplishment in the research and publication arena. Although Dr. Zaldivar is certified as a B-reader, a qualification that Dr. Koenig does not possess, I find that greater expertise in x-ray interpretation for the presence of clinical pneumoconiosis is not particularly relevant in assessing a physician's level of expertise in diagnosing legal pneumoconiosis. Thus, on the basis of relative qualifications, I find that Dr. Koenig's opinions are entitled to greater deference.

I also find after considering such factors as the explanations of their conclusions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses, that Dr. Koenig's opinion (*i.e.*, that it is medically reasonable to conclude that the Claimant's exposure to coal mine dust caused, contributed to or aggravated the Claimant's lung abnormalities and disabling respiratory impairment, which supports the diagnoses of legal pneumoconiosis made by Drs. Rasmussen and Doyle) is deserving of greater weight than the contrary opinion from Dr. Zaldivar. As I have already pointed out, Dr. Koenig cited several published studies to support his opinions, while Dr. Zaldivar cited none. Both doctors explained their conclusions, but I have given less weight to Dr. Zaldivar's explanations because of his evasiveness, as discussed above, in responding to legitimate questions which were especially relevant to the question of whether the Claimant had legal pneumoconiosis. Moreover, I find that Dr. Zaldivar's testimony that "coal workers' pneumoconiosis" causes "focal emphysema" is unpersuasive as an attempt to rebut Dr. Koenig's opinion, which is based on published medical studies, that coal mine dust exposure and cigarette smoking both cause the same type of emphysema, since Dr. Zaldivar testified that "focal emphysema" and clinical pneumoconiosis

[12] Since they are not board-certified in pulmonary disease, I find that Dr. Zaldivar's medical qualifications exceed those of Drs. Rasmussen and Dr. Doyle.

are the same thing. *See* Hearing Transcript at 156 (where Dr. Zaldivar states that there is no distinction between radiographic evidence of coal workers' pneumoconiosis and focal emphysema and that "[o]nce one finds radiographic pneumoconiosis, one has, by definition, focal emphysema present."). In my view, this is tantamount to a claim that unless a miner has radiographic or pathology evidence of focal emphysema (a/k/a clinical pneumoconiosis), his or her emphysema cannot be connected to coal mine employment. This comes perilously close to crossing the elusive line that separates reasoned medical opinions from those that are voidable as inimical to the Act's definition of legal pneumoconiosis, and it certainly lends some credence to Dr. Koenig's above-noted *reductio* to which Dr. Zaldivar took great umbrage.[13] While I will not go so far as rejecting Dr. Zaldivar's reasoning as hostile to the Act since this would likely precipitate a fourth remand from the Board, I do find that his discussion of clinical pneumoconiosis and focal emphysema is not responsive to Dr. Koenig's opinion that the Claimant's coal mine dust exposure caused or contributed to his bullous emphysema.

As a final matter, Hobet argues that Dr. Koenig's opinions are suspect because he only reviewed Dr. Zaldivar's May 14, 1997 report and not any of the other examination reports or objective testing. Employer's Brief on Remand at 22-23. It additionally states that the Board has held that greater weight may be accorded to a physician's opinion that is supported by more extensive documentation over that supported by limited medical data. Hobet is right that Dr. Koenig only reviewed Dr. Zaldivar's report. However, Dr. Zaldivar's report contains a thorough and detailed summary of the relevant medical evidence, and Dr. Koenig had no quarrel with any of Dr. Zaldivar's findings and diagnoses aside from those which reject a diagnosis of legal pneumoconiosis by ruling out any contribution from the Claimant's coal mine employment. Thus, Dr. Koenig had access to the very same medical data reviewed by Dr. Zaldivar, and I decline to give any greater credence to Dr. Zaldivar's opinions on the ground that he personally examined the Claimant in light of his testimony that the examination "was relatively incomplete" due to the fact that he was unable to have the Claimant undergo a pulmonary function study. Employer's Exhibit 6 at 23.[14]

For these reasons, I find that Dr. Koenig's reasoned medical opinion that it is reasonable to conclude that the Claimant suffered from legal pneumoconiosis is not outweighed by the reports and testimony from Dr. Zaldivar.

Dr. Fino

I previously gave little weight to Dr. Fino's opinions because I found that that his

[13] It is noted that Dr. Zaldivar similarly stated in his 1997 report that the fact a majority a x-ray readers found no radiographic evidence of pneumoconiosis "means that the dust burdens on the lungs if any is very small and not sufficient to have caused any pulmonary impairment because there is no reaction to the dust by the lungs which could be seen radiographically." Employer's Exhibit 1 at 8-9. This is further evidence of Dr. Zaldivar's narrow focus on clinical pneumoconiosis.

[14] During pre-hearing proceedings on the Claimant's November 30, 1995 modification request, Judge Miller ruled that the Claimant would only have to undergo a limited examination consisting of a chest x-ray unless waived by Hobet, resting arterial blood gas study and general physical examination, but no pulmonary function study. Administrative Law Judge Exhibits 5, 9.

position, which he expressed in this case, that coal dust inhalation does not produce a purely obstructive impairment had been rejected by the Department of Labor as not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature. Second D&O on Remand at 25-26, citing 65 Fed.Reg. 79,920, 79,939 (Dec. 20, 2000) and *Freeman United Coal Mining Co. v. Summers*, 272 F.3d 473, 483 (7th Cir. 2001).[15] The Board rejected my rationale for discrediting Dr. Fino's opinion for the following reasons:

> The DOL's comments, however, do not foreclose an administrative law judge from making his own assessment of the credibility of Dr. Fino's opinion in any given case. In this case, the administrative law judge did not make such an independent assessment.
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> * * * * *
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> The administrative law judge, in this case, failed to explain what particular statements made by Dr. Fino were "not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature." Consequently, the administrative law judge's analysis of the evidence does not comply with the requirements of the Administrative Procedure Act, specifically 5 U.S.C. §557(c)(3)(A), which provides that every adjudicatory decision must be accompanied by a statement of findings of fact and conclusions of law and the basis therefor on all material issues of fact, law or discretion presented in the record.
>
> * * * * *
>
> Accordingly, the administrative law judge, on remand, is instructed to provide a basis for his finding that any particular physician's views are not in accord with the medical and scientific literature.

Terry IV at 8-9. The Board also noted that the Fourth and Seventh Circuits have held that a doctor's expression of views that are hostile to the Act do not automatically exclude the doctor's opinion from consideration:

> The instant case arises within the jurisdiction of the United States Court of Appeals for the Fourth Circuit. In an unpublished case arising in the Fourth Circuit, a claimant argued that the administrative law judge should have

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[15] In *Summers*, the Court made the following observation:

> Dr. Fino stated in his written report of August 30, 1998 that "there is no good clinical evidence in the medical literature that coal dust inhalation in and of itself causes significant obstructive lung disease. " (Br. Supp. Pet. Modif'n at 23 (March 10, 1999)). During a rulemaking proceeding, the Department of Labor considered a similar presentation by Dr. Fino and concluded that his opinions "are not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature." 65 Fed.Reg. 79,920, 79,939 (Dec. 20, 2000).

272 F.3d at 483 n.7.

> discredited an opinion provided by Dr. Fino because the Fourth Circuit had found that Dr. Fino rendered an opinion hostile to the Act in another, unpublished, case two years earlier. The Fourth Circuit held that, contrary to the claimant's assertion, Dr. Fino's opinions in another case did not bear on the adequacy of his testing, reasoning and conclusions in the claimant's case. *Terry v. Bethenergy Mines, Inc.*, 151 F.3d 1030 (table), 1998 WL 2372612 (4th Cir. 1998) (unpublished).
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> * * * * *
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> Even if the administrative law judge had properly found that Dr. Fino expressed opinions hostile to the Act, the Seventh Circuit has held that a physician's expression of a view that is at odds with the Act is not enough by itself to exclude that opinion from consideration. Rather, the administrative law judge must determine whether, and to what extent, the hostile opinion affected the physician's medical diagnoses. *See Wetherill v. Director, OWCP*, 812 F.2d 376, 9 BLR 2-239 (7th Cir. 1987); *see also Lane v. Union Carbide Corp*., 105 F.3d 166, 21 BLR 2-34 (4th Cir. 1997).

Id. at 9 n.7, n.8.[16] Pursuant to the Board's instructions, I have again independently considered Dr. Fino's reports to determine whether his views are not in accord with the medical and scientific literature or hostile to the Act and, if so, whether, and to what extent, such views affected his medical opinions. Dr. Fino found no evidence that the Claimant had any pulmonary condition or impairment related to inhalation of coal dust based on the following findings:

> 1. <u>The majority of chest x-ray readings are negative for pneumoconiosis</u>.
>
> 2. <u>The spirometric evaluations that have been performed show a pure obstructive ventilatory abnormality</u>.
>
> * * * * *
>
> This type of finding is not consistent with a coal dust related condition but is

[16] It is respectfully noted that the Court in *Terry v. Bethenergy Mines, Inc*., 151 F.3d 1030, 1998 WL 372612 (4th Cir. 1998) (correct citation) did not hold that "Dr. Fino's opinions in another case did not bear on the adequacy of his testing, reasoning and conclusions in the claimant's case" as represented by the Board. The opinion at issue in *Bethenergy Mines* was authored by a Dr. Morgan who opined that the claimant did not have pneumoconiosis because his employment in the coal mines occurred mostly as a foreman and after the Act's imposition of stricter air quality standards in the mines. The ALJ rejected Dr. Morgan's opinion on the existence of pneumoconiosis because he found Dr. Morgan's premise about exposure after the imposition of air standards to be inimical to the Act, but he credited Dr. Morgan's opinion that the claimant was not totally disabled. The Court rejected the claimant's argument that the ALJ should not have credited Dr. Morgan's disability opinion because it found that his views on pneumoconiosis "did not bear in any way on his assessment of the issue of disability" which "hinged primarily on his evaluation of the objective laboratory tests" that had been similarly interpreted by all the other physicians. 1998 WL 372612**2. *Bethenergy Mines* is clearly distinguishable from the instant case where Dr. Fino's views on the nature and characteristics of pneumoconiosis go directly to the question of whether the Claimant had legal pneumoconiosis and not to another unrelated element of benefit entitlement such as the presence of a totally disabling respiratory or pulmonary impairment.

consistent with conditions such as cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma. This type of pattern is not consistent with a coal dust related lung condition. This pattern is consistent with a pure obstructive ventilatory abnormality as would be seen in asthma or in conditions related to cigarette smoking.

3. Reversibility following bronchodilators implies that the cause of the obstruction is not fixed and permanent. Certainly, pneumoconiosis is a fixed condition. Because it is fixed, bronchodilator medication would be of no benefit. One cannot improve on an abnormality caused by coal workers' pneumoconiosis. Hence, improvement following bronchodilators showing reversibility to the overall pulmonary impairment is clearly evidence of a non-occupationally acquired pulmonary condition causing the obstruction.

* * * * *

4. Coal mine dust inhalation causes an irreversible abnormality in the lungs which does not improve with bronchodilators. In other words, bronchodilators have no role or effect on the changes that may occur as a result of coal mine dust inhalation.

In addition, there is no good clinical evidence in the medical literature that coal mine dust inhalation in and of itself causes significant obstructive lung disease irrespective of its ability to be reversed following bronchodilators. Nevertheless, the use of bronchodilators is not consistent with treatment of a coal mine dust-related lung condition.

5. This individual does not experience hypoxia with exercise, thus indicating no oxygen transfer impairment.

The patient has an obstructive abnormality with an elevation in the lung volumes and a reduction in the diffusing capacity all consistent with a cigarette smoking induced pulmonary condition.

He does not have any of the typical abnormalities seen in an interstitial pulmonary condition. Pneumoconiosis is the cause of an interstitial pulmonary condition. An interstitial pulmonary condition is caused by pulmonary fibrosis in the interstitium of the lung.

* * * * *

What we see in this particular case is a pure obstructive ventilatory abnormality with no evidence of interstitial disease. I would note that pneumoconiosis is an interstitial pulmonary condition, and in fact there is no evidence of an interstitial pulmonary condition based on this information. He has a mild respiratory impairment with no oxygen transfer impairment and this is related to cigarette

smoking. It has nothing to do with the inhalation of coal mine dust.

Director's Exhibit 41 (March 7, 1995 Report) at 14-16 (underlining added). In a July 2, 1997 report, Dr. Fino stated that he disagreed with physicians who related the Claimant's bullous emphysema to coal mine dust inhalation because,

> there is no medical literature to support that claim. Bullous emphysema is not seen in simple pneumoconiosis. Bullous emphysema is a disease of the general medical population that is associated with cigarette smoking and can also be associated with a hereditary or congenital condition. In this particular case, there is no causal association between the bullous emphysema that is present and coal mine dust inhalation.

Employer's Exhibit 3 at 15. Dr. Fino further stated that the Claimant's pneumothoraces were "unrelated to the inhalation of coal mine dust" and that he did not find "any evidence of pneumoconiosis or impairment due to coal mine dust inhalation." *Id.* at 16. Lastly, Dr. Fino stated in his April 13, 1998 report, in which he reviewed Dr. Cohen's opinions, that bullous changes in the lungs can cause a pneumothorax, but "there is no increased incidence of pneumothorax in simple pneumoconiosis or in coal miners." Employer's Exhibit 17 at 2. While he agreed with Dr. Cohen that the Claimant had significant lung problems, he said that he did "not believe that they have been caused in whole or in part as a result of coal mine dust exposure." *Id.*

As I have quoted above, Dr. Fino stated in his March 7, 1995 report that "there is no good clinical evidence in the medical literature that coal mine dust inhalation in and of itself causes significant obstructive lung disease" which is exactly the same statement that he made in the rulemaking and which the Department of Labor found to be "not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature." 65 Fed.Reg. at 79,939 (Dec. 20, 2000). Since no evidence has been placed in this record to rehabilitate Dr. Fino's position, I find that his continued adherence to this view undermines the credibility of his opinion that there is no evidence that the Claimant suffered from any lung condition or impairment related to his inhalation of coal mine dust. Additionally, I find that Dr. Fino's reliance on negative x-ray interpretations, the absence of interstitial lung disease and the presence of a "purely obstructive" impairment in concluding that there is no evidence that the Claimant had any pulmonary condition or impairment related to inhalation of coal dust shows that he was overwhelmingly focused on the presence of clinical pneumoconiosis rather than legal pneumoconiosis which includes obstructive impairments. Accordingly, I find that his opinions carry relatively little probative weight in opposing the diagnoses of legal pneumoconiosis, and I conclude that his opinions do not, therefore, outweigh the findings of Drs. Rasmussen, Doyle and Koenig. *See Consolidation Coal Co. v. Swiger*, 98 Fed.Appx. 227, 2004 WL 1049097**8 (4th Cir. 2004). Like Dr. Zaldivar, Dr. Fino is board-certified in internal medicine and pulmonary disease, and he is a certified B-reader. Director's Exhibit 41. These qualifications approach those of Dr. Koenig and exceed those of Drs. Rasmussen and Doyle, but I find that they do not compensate for the deficiencies in Dr. Fino's reasoning which undermine the persuasiveness of his opinion that the Claimant did not suffer from any lung condition related to the inhalation of coal mine dust.

Dr. Hippensteel

I discredited Dr. Hippensteel's opinions because he "attributed the Claimant's emphysema to congenital causes and his mild obstructive impairment to cigarette smoking but failed to provided any explanation as to why these conditions are not also significantly related to or substantially aggravated by his exposure to coal mine dust." Second Decision and Order on Remand at 25. The Board disagreed with this assessment, stating,

> Although Dr. Hippensteel did not explicitly explain why claimant's bullous emphysema was not aggravated by coal dust exposure, he opined that claimant did not suffer from a coal dust related lung disease. Employer's Exhibit 7. Moreover, Dr. Hippensteel opined that claimant's bullous emphysema was congenital in nature, thus, providing an etiology for the disease. Director's Exhibit 43; Employer's Exhibit 10. We, therefore, hold that the administrative law judge's basis for discrediting Dr. Hippensteel's opinion cannot stand.

Terry IV at 10 (footnotes omitted). The Board also noted that Dr. Hippensteel had made the following statements: that the evidence was insufficient to make a diagnosis of pneumoconiosis or coal dust related disease; that the Claimant's bullous emphysema likely had some congenital component; and that the Claimant suffered from bullous emphysema with blebs, a congenital problem unrelated to coal workers' pneumoconiosis. *Id*. at 10 n.9, n.10.

In light of the Board's holding, I have reconsidered Dr. Hippensteel's reports and find that his opinions are not sufficiently reasoned to outweigh the findings of legal pneumoconiosis. In his first report, Dr. Hippensteel stated,

> The majority of expert readers have interpreted this man's x-ray as negative for coal workers' pneumoconiosis but even if it were stipulated that this man had a mild form of pneumoconiosis it would not be suggestive of coal workers' type of pneumoconiosis since the densities are mostly in his lower lung zones which is atypical for CWP. This man had bullous emphysema changes in his upper lobes, and in fact had previous surgery because of this problem causing recurrent pneumothoraces. Blebs like this are often congenital but can be aggravated by such things as cigarette smoking. Bullous changes are not a feature of coal workers' pneumoconiosis.

Director's Exhibit 43 (March 8, 1995 report) at 11 (underlining added). In his next report, Dr. Hippensteel reviewed additional medical records and stated,

> These additional medical records do not show additional objective data that changes my conclusions from previous extensive reports reviewed in this case. As stated in my previous reports, I think the evidence overall is insufficient to make a diagnosis of coal workers' pneumoconiosis or coal dust related disease of his lungs. In addition, he has much more symptomatology than can be shown objectively on tests. For this reason, it is useful to look at objective valid tests in

> these records to make conclusions about permanent impairment. Variable or partially reversible impairment is not consistent with that caused by coal workers' pneumoconiosis. I disagree with opinions of Dr. Rasmussen as noted above. I believe that even if it were stipulated that coal workers' pneumoconiosis were present in this man, then he still has good enough pulmonary function to return to his previous job in the mines based upon the findings that he does not have either permanent gas exchange impairment or ventilatory impairment to a degree to keep him from doing such work. In my opinion, the abnormalities in his not from coal workers' pneumoconiosis, but are secondary to congenital bullous emphysema with compression of lung markings in the lower lungs fields that shows up as mainly irregular shaped markings not typical for coal workers' pneumoconiosis. These conclusions are made with a reasonable degree of medical certainty based upon the objective evidence from all of the records reviewed regarding this case.

Employer's Exhibit 7 at 14-15 (underlining added). Dr. Hippensteel similarly stated in his March 20, 1998 report that there was "insufficient evidence to make a diagnosis of coal workers' pneumoconiosis." Employer's Exhibit 10, Report at 4. Although Dr. Hippensteel's reports do contain some passing and unexplained references to coal dust exposure, I find that he was overwhelmingly focused on the question of whether the Claimant suffered from clinical pneumoconiosis. Consequently, I conclude that his opinions can carry little weight in offsetting the reasoned medical findings of legal pneumoconiosis despite his qualifications as a certified B-reader and board-certified specialist in internal medicine and pulmonary disease.

Drs. Daniel, Kress and Morgan

The Board agreed with Hobet's argument that I erred in finding that the medical reports from Drs. Daniel, Kress and Morgan were not probative with respect to the existence of legal pneumoconiosis because they only discussed whether there is sufficient evidence to support a diagnosis of clinical pneumoconiosis. In this regard, the Board stated,

> Although Dr. Daniel diagnosed chronic obstructive pulmonary disease, he indicated that the disease did not arise out of coal dust exposure. Director's Exhibit 35. Dr. Kress opined that claimant did not suffer from coal workers' pneumoconiosis. Director's Exhibit 35. Although Dr. Kress opined that coal dust exposure may have been a contributing factor to claimant's chronic bronchitis, he opined that claimant's pulmonary emphysema was due to smoking and was not related to coal dust exposure. *Id.* In a supplemental report dated January 12, 1988, Dr. Kress opined that claimant's mild obstructive ventilatory impairment was not related to coal mine employment, but was caused by smoking. *Id.* Dr. Morgan opined that claimant did not suffer from coal workers' pneumoconiosis.

> Director's Exhibit 35. Dr. Morgan attributed the irregular opacities on claimant's x-rays to cigarette smoking. *Id.* Dr. Morgan further opined that the abnormalities were not related to coal dust. *Id.* Dr. Morgan found no evidence to suggest that coal mine dust exposure made any contribution to claimant's impairment. *Id.* Thus, contrary to the administrative law judge's characterization, the opinions of Drs. Daniel, Kress and Morgan are relevant to the issue of "legal" pneumoconiosis because they indicated that claimant's lung disease did not arise out of his coal dust exposure.

Terry IV at 11 (footnote omitted). Pursuant to the Board's decision, I have reconsidered the reports from these physicians and find for the following reasons that, while relevant, they have relatively limited probative value on the issue of legal pneumoconiosis and certainly do not outweigh the reasoned findings of legal pneumoconiosis made by Drs. Rasmussen, Doyle and Koenig.

The opinion from Dr. Daniel is found on an examination report form dated April 21, 1981 which he submitted to the OWCP. Director's Exhibit 35 (formerly marked as Director's Exhibit 17). He diagnosed COPD and checked a box indicating that this condition was not related to dust exposure in the Claimant's coal mine employment. By way of explanation, Dr. Daniel wrote, "No x-ray evidence of pneumoconiosis. Evidence of mild to moderate pulmonary dysfunction." Former Director's Exhibit 17 at 4. In my view, Dr. Daniel's reference to the absence of positive x-ray evidence indicates that he was primarily, if not exclusively, focused on whether the Claimant suffered from clinical pneumoconiosis. But, even assuming that his opinion is construed as negating the presence of legal pneumoconiosis, I give it little weight in view of his failure to provide any explanation of his conclusions aside from the absence of x-ray evidence of pneumoconiosis, and because the date of his examination (1981) establishes that he formed his opinions without benefit of the vast majority of the medical evidence that was subsequently developed.[17]

In his report which is dated April 27, 1988, Dr. Kress initially concluded that there was "insufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis" which, he explained, must be established by chest x-ray evidence of "small round opacities" which is an unmistakable reference to clinical pneumoconiosis. Director's Exhibit 35 (formerly marked as Employer's Exhibit 6 at 5). He also found that the Claimant had chronic bronchitis and emphysema and stated that "coal dust exposure may have been a contributing factor to his chronic bronchitis but certainly has no relationship, whatever to any emphysema that he may have which is obviously due to his smoking history." Former Employer's Exhibit 6 at 6-7. He further stated that "dust exposure, if excessive, may result in chronic bronchitis and an obstructive pulmonary impairment but not in pulmonary emphysema which, in the absence of an inherited alpha 1 antitrypsin deficiency, the presence of bronchiectasis or cystic fibrosis, or far advanced pneumoconiosis such as progressive, massive fibrosis is invariably due to cigarette smoking." *Id*. at 7. He added that he did not believe that the Claimant's coal mine employment with its attendant dust exposure had resulted in any "significant" respiratory impairment. *Id.* In a subsequent report dated September 12, 1988, Dr. Kress stated that while he found that the Claimant had a mild obstructive impairment, it was related to his smoking history and not to coal

[17] Dr. Daniel's qualifications are not in the record.

mine employment. Director's Exhibit 35 (formerly marked as Employer's Exhibit 1). I find that Dr. Kress's statements are contradictory. On the one hand, he said in his first report the Claimant had chronic bronchitis which may be related to coal mine dust exposure and that dust exposure can also produce an obstructive impairment. Given that virtually all physicians agree that the Claimant has an obstructive impairment, this would seem to support a diagnosis of legal pneumoconiosis. On the other hand, Dr. Kress stated in his second report that the Claimant had developed a mild obstructive impairment which was unrelated to coal mine dust exposure and instead caused by cigarette smoking. Since he did not explain this apparent contradiction or provide any explanation for his belief that the Claimant's mild obstructive impairment was related to smoking and not coal mine dust exposure, I find that his opinion that the Claimant did not have any "significant" impairment related to his coal mine employment is not sufficiently reasoned to outweigh the medical diagnoses of legal pneumoconiosis. In addition, his opinions were rendered in 1988 before much of the relevant medical evidence, including the diffusing capacity study results showing that the severity of the Claimant's respiratory impairment had progressed to the totally disabling level, came into existence. Dr. Kress is a certified B-reader and has specialized in industrial pulmonary evaluation since 1979. Director's Exhibit 35. Although his qualifications and experience are somewhat comparable to those of Dr. Rasmussen, I find that his credentials are not a substitute for a reasoned opinion.

Finally, Dr. Morgan, whose April 7, 1988 report is found at Director's Exhibit 35 (formerly marked as Employer's Exhibit 7), concluded from his review of the medical evidence that the Claimant had a mild obstructive respiratory impairment, but he found that there was nothing to suggest that coal mine dust exposure made any contribution to this impairment. He made the following comments in arriving at this conclusion: (1) the mild obstructive impairment "is best explained by Mr. Terry's habit of cigarette smoking"; (2) the Claimant's reduced diffusing capacity is consistent with emphysema and airways obstruction; (3) he did not believe that the Claimant had "coal workers' pneumoconiosis" because the abnormalities shown on his chest x-rays are of the type seen in smokers which are different from the small, round opacities seen in cases of coal workers' pneumocioiosis; and (4) "there is clear cut evidence that surface workers are exposed to relatively small concentrations of coal dust and one does not seen [sic] pneumoconiosis present in them unless they have been drillers or have previously worked underground." Former Employer's Exhibit 7 at 7-8.[18] In support of this last point, Dr. Morgan referred to "the chapter on coal workers' pneumoconiosis in our book" and stated that "the appropriate references are given to dust levels measured by the Bureau of Mines or what is now called EMCHA." *Id.*[19] Thus, Dr. Morgan's only articulated bases for believing that coal mine dust exposure did not contribute to the Claimant's respiratory impairment were the absence of

[18] The Claimant testified at the October 24, 1988 hearing before Judge Huddleston that his coal mine employment took place in surface or strip mines. Director's Exhibit 35, Hearing Transcript at 23-26.

[19] Dr. Morgan's *curriculum vitae*, which is appended to his report, does not list any publications, so his reference to "our book" is inscrutable. It is noted that Hobet recites Dr. Morgan's credentials, which include several publications, in its brief. Employer's Brief on Remand at 15 n.14. Thus, it would appear that "our book" refers to one of the publications predating Dr. Morgan's report on the Claimant. I have considered Dr. Morgan's qualifications as reflected by his *curriculum vitae* and find that his education, experience and professional accomplishments are at least comparable to those of Dr. Koenig. However, for the reasons discussed above, I find that his report is significantly inferior to that of Dr. Koenig in terms of the quality of the reasoning and detail of explanation relevant to the presence of legal pneumoconiosis.

chest x-ray evidence compatible with clinical pneumoconiosis and his assumption that surface miners other than drillers do not develop pneumoconiosis. This reasoning runs counter to the Act and regulations which permit any person meeting the definition of "miner" to prove that his or her obstructive lung disease arose out of coal mine employment, including surface mining, thereby satisfying the definition of legal pneumoconiosis. *See Nat'l Mining Ass'n v. Chao*, 160 F. Supp.2d 47, 79 (D.D.C. 2001), *overruled in part on other grounds sub nom Nat'l Mining Ass'n. v. Dep't. of Labor*, 292 F.3d 849 (D.C. Cir. 2002). *See also Consolidation Coal Co. v. McGrath,* 866 F.2d 1004, 1006 (8th Cir. 1988) (rejecting employer's argument that claims from surface miners should be subjected to greater scrutiny due to a lower incidence of pneumoconiosis, and holding that "[t]his contention, for which the company provides no authority, clearly contradicts the relevant statutory provisions, which do not distinguish surface mining from other forms of mining."); *Battaglia v. Peabody Coal Co*., 690 F.2d 106, 111 (7th Cir. 1982) (upholding application of the 1977 amendments and implementing regulations to a deceased surface miner since "the facts show that surface miners do contract pneumoconiosis, however small the numbers may be"). For these reasons, I find that Dr. Morgan opinion, while perhaps sufficient to support a finding of no clinical pneumoconiosis, is not adequately reasoned and documented in terms of negating the credited medical findings of legal pneumoconiosis. Accordingly, I have given his opinion little weight.

Based on the foregoing assessment, I find that the medical opinions from Drs. Zaldivar, Fino, Hippensteel, Daniel, Kress and Morgan do not outweigh the reasoned findings of legal pneumoconiosis provided by Drs. Rasmussen, Doyle and Koenig. In making his finding, I have given the greatest weight to the opinions of Dr. Koenig in view of his superior credentials, explanation of his conclusions and underlying documentation, as well as the greater level of sophistication reflected in the bases for his diagnosis of legal pneumoconiosis. While Drs. Zaldivar, Fino, Hippensteel, Kress and Morgan all have similarly impressive credentials, I find that, both individually and as a group, their opinions are less well-reasoned and documented in terms of their treatment of legal pneumoconiosis than the opinions from Drs. Koenig, Rasmussen and Doyle. In short, as I have stated above, credentials do not compensate for qualitatively inferior analysis and reasoning.

D. Was the Claimant totally disabled due to his legal pneumoconiosis?

In my last decision on remand, I found on the basis of the reasoned opinions from Drs. Rasmussen and Doyle, which I found supported by the opinions from Drs. Koenig, Cohen, Figueroa and Marciales, that the evidence established that the Claimant's legal pneumoconiosis was a substantially contributing cause of his total disability as required by 20 C.F.R. § 718.204(c). I also discounted the disability causation opinions from Drs. Zaldivar, Fino, Hippensteel, Daniel, Kress and Morgan since they were premised on the erroneous assumption that the Claimant's lung impairment was unrelated to coal mine dust exposure which is irreconcilable with my finding that the Claimant suffered from legal pneumoconiosis. Having again found that the Claimant suffered from legal pneumoconiosis, my analysis and determination on the disability causation issue is unchanged, and I again find that the Claimant

has established by a preponderance of the evidence that his total disability was due to pneumoconiosis within the meaning of the Act.[20]

III. Conclusion

Having determined on remand that the Claimant has proved by a preponderance of the evidence that he was totally disabled due to pneumoconiosis, I conclude that his estate is entitled to an award of benefits to be paid by Hobet as the responsible mine operator. Since the date of onset of total disability due to pneumoconiosis cannot be precisely ascertained on this record, benefits are payable from the first day of the month in which the current claim was filed. 20 C.F.R. § 725.503(b).

IV. Order

The claim of Harold Terry for benefits under the Act filed on October 18, 1993 is **GRANTED**, and Hobet Mining, Inc., as the responsible operator, shall pay to his estate all benefits to which he is entitled under the Act, commencing October 1993.

SO ORDERED.

A

Daniel F. Sutton
Administrative Law Judge

Boston, Massachusetts

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. '725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within thirty days from the date of this decision by filing a Notice of Appeal with the Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Francis Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

[20] In view of my finding on remand that Drs. Cohen, Figueroa and Marciales did not diagnose legal pneumoconiosis, I have not relied on their opinions regarding disability causation. This, however, does not alter the evidentiary balance since the credited opinions from Drs. Rasmussen, Doyle and Koenig are more than sufficient to overcome the contrary causation opinions from Drs. Zaldivar, Fino, Hippensteel, Daniel, Kress and Morgan.